United States Premier Hockey League
Insurance Summary
4/1/24 - 4/1/25

Excess Participant Accident
Catastrophic Accident
General Liability

PLAYERS HEALTH

Excess Participant Accident

Insurance Company:	Great American Insurance Company
Effective Date:	April 1, 2024 - April 1, 2025
Policy Number:	BSR E880709 - 00
Eligibility:	All registered players, coaches, manager, referees, officials, staff and volunteers participating in covered activities of the National Collegiate Development Conference, Premier Division, or Elite Division while participating in scheduled tryout sessions, scheduled team practice sessions, schedule games, tournaments and other sponsored activities under the direct supervision of a Sponsoring Organization team official. (100% Participation)
Coverage Description:	Policy provides AD&D and Excess Participant Medical Expense for Eligible Persons injured during a covered activity of USPHL subject to the policy's declaration, conditions, and exclusions.

Policy Benefits

Accidental Death & Specific Loss	
Loss of Life Principal Sum	$15,000
Specific Loss Principal Sum	$50,000
Loss Period	Loss within 365 Days of Injury
Paralysis Benefit	
Principal Sum Amount	$50,000
Hemiplegia	100% of Principal Sum
Paraplegia	100% of Principal Sum
Quadriplegia	100% of Principal Sum
Loss Period	Within 365 days after the date of the accident and continuing for one year
Full Excess Medical Expense	
Maximum Benefit Amount	$50,000 per Injury
Benefit Percentage	70% of reasonable charges
Accident Medical Deductible - Corridor	$2,500 per Injury with primary insurance $5,000 per Injury without primary insurance

Loss Period	Initial treatment received within 30 days of accident date
Benefit Period	
Durable Medical Equipment	Benefits payable for 104 weeks from date of covered accident
Orthopedic Appliances	Not to Exceed 100% of the Allowable Expense per Injury
Dental Expense	Not to Exceed 100% of the Allowable Expense per Injury
Prescription Drug Expense	Not to Exceed 100% of the Allowable Expense per Injury
Outpatient Physical Therapy Expense	$50 per visit up to $2,000 per Injury
Notable Exclusions:	intentionally self-inflicted injury, suicide while sane or insane, injury caused by intoxication, commitment of or an attempt to commit a felony, sickness, disease, dental treatment except when Injury occurs to sound natural teeth, losses paid under Workers Compensation or Employer's Liability, charges in excess of Allowable Expenses, elective treatment or surgery that is not prescribed by a Physician and is not Medically Necessary

Catastrophic Participant Accident

Insurance Company:	Mutual of Omaha Insurance Company
Effective Date:	April 1, 2024 - April 1, 2025
Policy Number:	CAT E880710 - 00
Eligibility:	All registered players, coaches, manager, referees, officials, staff and volunteers participating in covered activities of the National Collegiate Development Conference, Premier Division, or Elite Division while participating in scheduled tryout sessions, scheduled team practice sessions, schedule games, tournaments and other sponsored activities under the direct supervision of a Sponsoring Organization team official.
Coverage Description:	Policy provides additional AD&D and Excess Participant Medical Expense limits over the base Excess Participant Medical placement (policy BSR E880709 - 00

Schedule of Benefits: Coverage Class 1: Policy Limits & Deductible

Aggregate Limit

Aggregate Benefit Maximum: $300,000
Applies To: Accidental Death and Accidental Dismemberment Benefits

Accidental Death and Dismemberment Benefits

Principal Sum:

Accidental Death: $5,000
Accidental Dismemberment: $5,000

Incurral Period:

Accidental Death & Dismemberment: 365 Days

Covered Losses: Accidental Death, Accidental Dismemberment

Optional Additional Benefits:

Benefit Benefit Amounts:

Catastrophic Accident Medical Expense Benefits:

Incurral Period: 180 Days
Benefit Maximum: $2,000,000
Deductible: $50,000
Deductible Incurral Period: 104 Weeks from the date of the covered accident

Maximum Benefit Period: 10 Years from the date of covered accident

Scope of Coverage: Excess Coverage

Commercial General Liability

Insurance Company: State National Insurance Company

Effective Date: April 1, 2024 - April 1, 2025

Policy Number: OVR-0000007-02

Named Insured: United States Premier Hockey League, LLC and its member associations, leagues, clubs, teams, players, coaches and referees; however, except for United States Premier Hockey League, LLC, none of these are Insureds for liability arising out of their participation in games, practices, activities or operations not sanctioned or approved by United States Premier Hockey League, LLC.

Coverage Description: The Commercial General Liability policy protects the USPHL and its membership against claims involving bodily injury, personal injury, and property damage liability. Sexual Abuse & Molestation and Hired and Non-Owned Liability is also provided. Coverage subject to the policy's declaration, conditions, and exclusions.

Covered Activities: USPHL Sanctioned and approved ice hockey events, office Premises, insured event set up and tear down periods, concession sales at insured events, ancillary activities such as occasional fund-raising events, dinners, awards, banquets, and planning sessions.

Limits of Liability:

General Aggregate	$5,000,000
Products/Completed Operations Aggregate	$2,000,000
Personal and Advertising Injury	$1,000,000
Each Occurrence	$5,000,000
Damage to Premise Rented Limit	$300,000
Medical Expense Limit	$5,000
Participant Legal Liability Occurrence	$2,000,000
Participant Legal Liability Aggregate	$3,000,000
Neurodegenerative Injury Occurrence	$1,000,000

Neurodegenerative Injury Aggregate	$2,000,000
Sexual Abuse Occurrence	$1,000,000
Sexual Abuse Aggregate	$2,000,000
Hired and Non-Owned Liability	$1,000,000

Notable Exclusions: Coverage C Med Pay, Employment Practices Liability, Pollution, Lead, Asbestos, Radioactive Matter, Communicable Diseases, Unmanned Aircraft, Mold, Fungus, Bacteria, Silica, Carnivals, Circuses, Fireworks

Blanket Additional Insureds: As required by written contract or agreement. Others by request and endorsement, subject to underwriting approval.

General Liability - Claim Filing Instructions

If you have been served a civil lawsuit or become aware of a circumstance you believe could likely result in a future liability claim, please contact your league director or Players Health immediately for further instruction. Do not delay.

General Liability – Certificate of Insurance (COI)

Certificates of Insurance (COI) serve as evidence to the Certificate Holder (i.e., facility owner) that your organization has Commercial General Liability insurance for its operations. The CGL policy contains a blanket Additional Insured endorsement on the policy when required by written contract or agreement which extends Additional Insures status to the Certificate Holder.

To obtain a COI, please fill out a request at https://landing.playershealth.com/certificates/ and make sure to include the following information:

1. Identify you are a member organization of United States Premier Hockey League
2. Provide your club and/or team name
3. Name and complete mailing address of the facility owner. Please double check with the facility owner for any specific requirements or special wording needed BEFORE requesting the COI.
4. Provide email address for person at the facility requesting the COI. The COI will be delivered via email to the person requesting the COI as well as the facility contact, if provided.

COI requests will be processed and emailed back to you within 48 hours, if not sooner.

Directors & Officers Liability and Crime Coverage

Directors & Officers Liability

The United States Premier Hockey League recommends member teams / clubs procure Directors & Officers (D&O) Liability coverage. D&O policies provide coverage for allegations of wrongful acts, misleading statements, breach of duty, errors, or omissions involving the governance of the organization's affairs to include Employment Practice Liability and Third-Party Wrongful Acts (i.e. discrimination, civil rights violations). These types of claims are not covered under the General Liability policy form. Teams/ clubs are responsible for carrying their own D&O policy. If you need assistance with purchasing a D&O policy, please reach out to Jack Ramsey at Players Health. He can be reached at jack.ramsey@playershealth.com

Crime

The United States Premier Hockey league also recommends that teams / clubs procure Crime coverage to protect themselves against embezzlement of funds by an employee or volunteer. Contact our Jack Ramsey at jack.ramsey@playershealth.com if you are interested in procuring the coverage.

Important Notice

This document is for illustrative purposes only and is not a contract of insurance. You must refer to the actual policies for complete information regarding coverage terms, conditions and exclusions.

About Players Health

Players Health is a sports services organization that provides digital risk management services, reporting tools, and insurance to sports organizations to comply with the changing athletic environment and responsibilities. Players Health works towards creating the safest environment for athletes and views the health and safety of athletes as a priority in today's sports landscape. This requires creating and maintaining products that provide a circle of care for safety, trust, accountability, and accessibility for athletes. In doing so, Players Health is a company where mission drives the business and creates an environment where people are valued above all else. For more information on Players Health, visit www.playershealth.com.

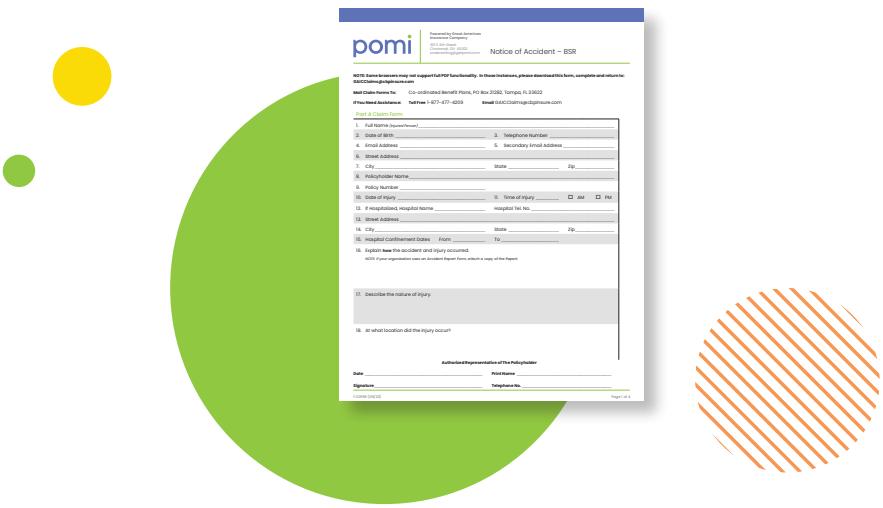
CLAIM FILING NOTICE-BSR

This claim form MUST be received by the Great American Insurance Company within 90* days of the date of injury. Benefits will be paid for eligible expenses left unpaid by other insurance or health plans. Expenses must be incurred within 52* weeks after the date of the accident.

*As otherwise noted in the Policy

CLAIM PROCEDURE

1. Have a Representative of the Policyholder complete, date and sign PART A.
2. The Injured Person (Insured) – or, if the Injured Person is under age 18 or is otherwise dependent, his/her Parent or Guardian – MUST complete, date and sign PART B.
3. After PARTS A and B have been completed in full, mail the form to the address shown above within 90 days of the date of injury.
4. Send all medical bills to your other health and accident insurance company(s) first, if applicable. This can include employee plans, union plans, service contracts, HMO Plans, self-insured benefit plans, etc.
5. After you have received a notice of payment from your other health and accident insurance company(s), notice of denial or letter stating you have met your deductible from your other insurance company(s), forward that statement, along with copies of the original bills, to the address shown above. You may also fax or email. Please see contact information shown above.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Notice of Accident – BSR

Part A Claim Form

Great American Insurance Group, 301 E. Fourth St., Cincinnati, OH 45202. This is an accident only policy with limited benefits and does not pay benefits for diseases, sickness or loss from sickness. Coverage is summarized. Coverage features and product availability may vary by state. This is not a contract for the coverage described herein. Please contact us or your agent/broker for additional information, and refer to the actual policy for a full description of applicable terms, conditions, limits and exclusions. Policies are underwritten by Great American Insurance Company, an authorized insurer in all 50 states and the DC. © 2020 Great American Insurance Company. All rights reserved. 5335-ACH-2 (9/20)

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Powered by Great American Insurance Company
301 E 4th Street
Cincinnati, OH 45202
underwriting@getpomi.com

Notice of Accident – BSR

NOTE: Some browsers may not support full PDF functionality. In those instances, please download this form, complete and return to: GAICClaims@cbpinsure.com

Mail Claim Forms To: Co-ordinated Benefit Plans, PO Box 21282, Tampa, FL 33622

If You Need Assistance: **Toll Free** 1-877-477-4209 **Email** GAICClaims@cbpinsure.com

Part A Claim Form

1. Full Name *(Injured Person)* _____
2. Date of Birth _____ 3. Telephone Number _____
4. Email Address _____ 5. Secondary Email Address _____
6. Street Address _____
7. City _____ State _____ Zip _____
8. Policyholder Name United States Premier Hockey League
9. Policy Number BSR E880709- 00
10. Date of Injury _____ 11. Time of Injury _____ ☐ AM ☐ PM
12. If Hospitalized, Hospital Name _____ Hospital Tel. No. _____
13. Street Address _____
14. City _____ State _____ Zip _____
15. Hospital Confinement Dates From _____ To _____
16. Explain **how** the accident and injury occurred.

    NOTE: If your organization uses an Accident Report Form, attach a copy of the Report.

17. Describe the nature of injury.
18. At what location did the injury occur?

Authorized Representative of The Policyholder

Date _____ **Print Name** Debra T. Madden

Signature _____ **Telephone No.** 603-886-8885

Part B

This PART MUST be completed, dated and signed by the Injured Person – or if the Injured Person is under age 18 or otherwise dependent – by his/her Parent or Guardian.

Print Here: Name of Person Completing Form _____

Check one: ☐ Injured Person ☐ Parent ☐ Guardian

Give the following information about the Injured Person:

1. Date of Birth _____ 2. ☐ Male ☐ Female

3. Social Security No. _____ 4. Area Code/Telephone No. _____

5. **Employer *(if applicable)***

   Name _____

   Street Address _____

   City _____ State _____ Zip _____

   Area Code/Employer Telephone No. _____

6. Is the Injured Person covered under any other health and/or accident insurance plans? **Yes** ☐ **No** ☐

   If yes, give the following information:

   Name of Other Insurance Company(s) _____

   Street Address _____

   City _____ State _____ Zip _____

   Area Code/Employer Telephone No. _____

   Policyholder Name _____

   Policy number _____

   Street Address _____

   City _____ State _____ Zip _____

   Social Security No. _____

   Relationship to Injured person _____ Area Code/Telephone No. _____

7. If the Injured Person is married, give the following information:

   Name of Spouse _____

   Social Security No. _____ Area Code/Telephone No. _____

8. Is the injured person eligible for Medicare/Medicaid? **Yes** ☐ **No** ☐

I authorize any insurer, hospital, physician or other person who has attended or examined the Insured Person to disclose, when requested to do so, all information with respect to any injury, policy coverages, medical history, consultation, prescription or treatment, and copies of all hospital or medical records and itemized bills. A photostatic copy of this authorization shall be considered as effective and valid as the original. The above information is true and complete to the best of my knowledge and belief.

I also authorize Great American Insurance Company or its agents or representatives to pay all bills in connection with this claim directly to the doctor, hospital or any other persons rendering service, and such payment shall release Great American Insurance Company from liability as to amounts so paid.

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime *(in FL, a felony in the third degree)*, and in the state of New York, shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature *(in writing)* of Responsible Party _____ **Print Name** _____

Check one: ☐ **Injured Person** ☐ **Parent** ☐ **Guardian** **Date** _____

SEE FOLLOWING PAGE FOR FRAUD WARNING NOTICES

Fraud Warning Notices

AK: Any person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

AL: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

AR, DC, LA, MD, NM, RI, TX, WV: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

AZ: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CA: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DE, ID, IN: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

FL: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

ME, TN, VA, WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.

MN: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NH: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in section 638:20.

NJ: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OH: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OK: Any person who knowingly, and with any intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Fraud Warning Notices *Continued*

PA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

ALL OTHER STATES: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties.

Submit

Powered by Great American Insurance Company
301 E 4th Street
Cincinnati, OH 45202
underwriting@getpomi.com

Loss of Life Document – Supplement to Claim Form

NOTE: Some browsers may not support full PDF functionality. In those instances, please download this form, complete and return to: GAICClaims@cbpinsure.com

Mail Claim Forms To: Co-ordinated Benefit Plans, PO Box 21282, Tampa, FL 33622

If You Need Assistance: **Toll Free** 1-877-477-4825 **Email** GAICClaims@cbpinsure.com

Part A Claim Form

Full Name of Deceased_____

Last Permanent Address of Deceased _____

City_____ State _____ Zip_____

Date of Death_____

Date Deceased Sustained The Accidental Injury That Caused His/Her Death_____

Cause of Death _____

How did the accident happen?

Attending Physician at Time of Death:

Name _____

Address _____

City_____ State _____ Zip_____

Phone _____

In what capacity, or by what title, do you claim this insurance?_____

(Beneficiary, executor, assignee, guardian, trustee, administrator)

The undersigned hereby makes claim to said insurance from Great American Insurance Company and agrees that the written statements of all Physicians who treated and attended the insured are accurate to the best of their knowledge. The undersigned further agrees that all other documentation required and the instructions provided constitute the full scope of the Proof of Death and also agrees that by providing the other supplemental documents shall not constitute an admission that there was any insurance in force on the life in question, nor a waiver of any of its rights or defenses.

Dated _____**, 20**_____ **Signature**_____

Print Name Debra T. Madden **Address** _____

City _____ **State**_____ **Zip**_____

CERTIFIED COPY OF DEATH CERTIFICATE MUST BE ATTACHED

Submit